CITY OF SCOTTSDALE FLEXIBLE SPENDING ACCOUNT CLAIM FORM

Administered by: Administrative Enterprises, Inc. • 5810 W. Beverly Lane • Glendale, AZ 85306-1800 • (602) 789-1170 Fax: (602) 789-1179

Please type or print. See reverse side for instructions and additional important information.

EMPLOYEE INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____

Street Unit No. City State Zip Code

☐ Check this box if address has changed since last claim was filed

HOME PHONE: (____) _____

WORK PHONE: (____) _____

HEALTH CARE REIMBURSEMENT

To ensure the prompt processing of your reimbursement request, please be sure to attach copies of your Explanation of Benefits statement prepared by your insurance carrier and any additional supporting documentation as described on the reverse of this form for each of the reimbursement requests listed below.

	Date of Service	Provider of Service	Amount of Reimbursement
1			
2			
3			
4			
5			
6			
7			
8			
		TOTAL REIMBURSEMENT REQUEST	

DEPENDENT CARE REIMBURSEMENT

Dependent Name/Relationship	Age	Dates of Service	Amount
		TOTAL REIMBURSEMENT REQUEST	

NAME OF DEPENDENT CARE PROVIDER: _____

SOCIAL SECURITY/ TAX ID NUMBER: _____

ADDRESS: _____

Street Unit No. City State Zip Code

SIGNATURE OF PROVIDER: _____ DATE: _____

(Not required if signed and itemized receipt is attached)

EMPLOYEE SIGNATURE

I hereby request payment from my Flexible Spending Account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I also certify that the total dependent care expenses (if any) for which I am requesting reimbursement this plan year do not exceed the lesser of my or my spouse's earned income for the year. I further certify that the expenses I am submitting for payment are eligible expenses, as explained in my enrollment materials. I understand that expenses paid through these accounts cannot be claimed on my personal income tax return.

EMPLOYEE SIGNATURE: _____ DATE: _____

IMPORTANT INFORMATION ON REIMBURSEMENTS

Health Care - Eligible Expenses: In general, you may be reimbursed for your out-of-pocket healthcare expenses that are not covered by your medical, vision or dental plans The expenses must be for medical purposes, must not be reimbursed by any other source and must not be deducted on your income tax return. Some examples of eligible expenses include co-payments, coinsurance, deductibles, vision, hearing, dental, prescription drug expenses and certain over-the-counter drugs expenses not covered by your health insurance, or your spouse's health insurance. Over-the-counter drugs are only eligible if they are used for medical purposes. They are not eligible if they are just beneficial to good health. For more information about eligible expenses, you should refer to your enrollment materials.

Dependent Care - Eligible Expenses: In general, the following rules apply to dependent care expenses:

- The annual amount submitted for reimbursement must be less than the lower of your income or your spouse's income.

- The expenses must be for the care of your dependent who is under age 13 and entitled to a dependent deduction under Internal Revenue Service code section 151(e) or a dependent who is physically or mentally incapable of caring for himself or herself.

- The care must be necessary in order for you and your spouse to work.

- The payments cannot be made to a person who is claimed as your dependent.

- If the services are provided by a dependent care center which provides care for more than six individuals, the center must comply with all state and local laws.

Supporting Documentation: The following supporting documentation must be submitted with this form:

- Expenses covered by your health care plans: Medical, dental and vision expenses covered by your health care plans must be submitted under those plans first. Attach a copy of the "explanation of benefits" statement to claim amounts not paid by your health care plans.

- Dependent Care Expenses: Complete the "Dependent Care Reimbursement" section on the front of this form and attach a signed receipt from your dependent care provider. If you do not have a signed receipt, have your dependent care provider supply the additional information requested in the "Dependent Care Provider" section of this form and sign in the space provided to verify that charges have been incurred. Submit all bills or receipts with your completed claim form.

- All other expenses: For all other expenses, submit bills that clearly state:

  - Name of person receiving the service
  - Name of service, supplies or drugs
  - Name and address of service provider
  - Amount charged
  - Date service was rendered

Send completed form to: Administrative Enterprises, Inc.
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